Central Bedfordshire
Safeguarding Children Partnership

Child Safeguarding Practice Review

Isabella

Independent Author: Dr Russell Wate QPM

Publication – February 2025

1.0 Introduction and Background to this Child Safeguarding Practice Review

1.1 On the 30th of June 2023, Bedfordshire Police contacted Suffolk Constabulary sharing a call that they had received from a friend of Isabella's mother. The friend had 'grave concerns' for Isabella (2 years and 9 months old) following a communication that the friend had received from the mother. Suffolk Constabulary attended a hostel in Ipswich, Suffolk, where the family were staying and discovered Isabella deceased, she was found in her buggy. It is assumed by the findings of the criminal investigation that Isabella had been dead for around three days and had suffered a number of significant non-accidental injuries.

1.2 A search began for the mother and her new boyfriend, who were no longer at the hostel. They were located in the early hours of the next morning in Bury St Edmunds, arrested, and were detained on suspicion of murder and have been subsequently charged with Isabella's murder. At the conclusion of the criminal trial, IMB was found guilty of the murder of Isabella and IM pleaded guilty to causing or allowing the death of Isabella. On the 13th of December 2024, IMB was sentenced to life imprisonment with a minimum of 26 years in custody. IM was sentenced to 10 years imprisonment.

1.3 Isabella originated from Central Bedfordshire and a number of agencies were involved in her life from across four different local authority areas. For the purposes of this report Isabella, which is her real name, will be used. When Isabella's father, paternal grandmothers and maternal grandmother and aunt, were seen by the report author they were all supportive of Isabella's name being used. Please see below table:

Isabella	Isabella
Isabella's Mother	IM
Isabella's Father	IF
Isabella's Mother's Boyfriend	IMB

1.4 Isabella, her mother IM, and IMB left Central Bedfordshire on the 1st of June 2023, travelling to Norfolk where they stayed for almost three weeks. On the 19th of June they arrived in Suffolk where they stayed until Isabella's death.

1.5 Because they were living in the hostel - which is a homeless accommodation in Suffolk - when Isabella died, Suffolk Safeguarding Children Partnership (SSCP) and Suffolk Child Death Overview Panel (CDOP) commenced an information gathering trawl. Suffolk CDOP hosted an initial information sharing meeting as per the Child Death Review (2017) statutory guidance. SSCP then hosted and led on a rapid review process and chaired a meeting in line with Chapter Four of the at that time in place 'Working Together to Safeguard Children' (2018.) The rapid review process was contributed to widely and the meeting was extremely well attended and the resulting report well written. Due to Isabella and her mother being residents of Central Bedfordshire, it was decided that Central Bedfordshire Safeguarding Children Partnership (CBSCP) would now take over the leadership and ownership of the agreed appropriate next step, which was to complete a local child safeguarding practice review (LSCPR).

1.6 The CBSCP appointed a panel of safeguarding leads from across the four relevant local authority areas, it also appointed an independent lead reviewer and report author, Dr Russell Wate QPM to assist the panel with the review and to produce the report on behalf of the panel and the CBSCP.

1.7 It was felt that the review should examine a timeframe for Isabella's life, using four key practice time periods:

- 01/01/2020 to 23/08/2021 to include pregnancy and Isabella's first year of life.
- 24/08/2021-30/04/2023 this covers the next period of Isabella's life until her parents separate.
- 01/05/2023-31/05/2023 this covers a period of alleged Domestic Abuse (DA) between Isabella's parents and then Isabella's mother starting a relationship IMB.
- 01/06/2023-30/06/2023 this is the period when Isabella, her mother, and IMB were on the move with Isabella across Norfolk and Suffolk.

1.8 The panel established a number of key learning themes for the review to focus on:

- Risk assessments

i) Were there any risks pre and post birth?
ii) Were there any times in the crucial last two or three weeks of Isabella's life where higher quality practice might have saved her life?
iii) Was Isabella's invisibility partly due to the speed with which the family moved around, and, if so, what mitigations are possible to reduce this risk?

- The unknown/grey area about IMB and the risks he posed.
- Response to alleged Domestic Abuse with children in the household.
- Information sharing between agencies in Central Beds/Norfolk/Suffolk during the final month of Isabella's life.
- Housing - when homeless and young children are involved.
- Considerations around intersectionality - race, disability, and health conditions, and whether these impacted on service delivery.
- Impact of Covid.

1.9 Individual Management Reviews (IMR) were requested and completed by agencies in all four local authority areas. The IMRs included critical analysis and reflection of engagement with Isabella and her family, identifying learning and recommendations both for the review, but also in their individual agency. Existing information provided to the rapid response process and for the meeting was reviewed as part of the IMR process and updated in the IMR as required. The below listed agencies are those that contributed to this review report:

Central Bedfordshire:

- Central Bedfordshire Council Children's Services (CBCCS)
- Bedfordshire IDVA Services (Victim Support)
- Central Bedfordshire Council Housing Services
- Bedfordshire – GP's (Information provided)
- Bedfordshire Police
- East London NHS Foundation Trust (Mental Health Services) (ELFT)
- Bedfordshire, Luton and Milton Keynes ICB
- Cambridgeshire Community Services (Community Health) (CCS)
- Two x Child Nurseries
- Bedford Hospital

Suffolk:

- Suffolk County Council - Children & Young People's Services
- Ipswich Borough Council – Housing Services
- Suffolk Constabulary
- East of England Ambulance Service (provided information in to the Rapid Review only)

Norfolk: • Norfolk County Council – Children's Services • Great Yarmouth Council – Housing Services • Norfolk Constabulary
Hertfordshire: • Lister Hospital - East and North Hertfordshire NHS Trust • Hertfordshire GP's (information provided) • Child Nursery (information provided)

Analysis

2.0 Risk assessments

i) Were there any risks pre and post birth?

ii) Were there any times in the crucial last two or three weeks of Isabella's life where higher quality practice might have saved her life?

iii) Was Isabella's invisibility partly due to the speed with which the family moved around, and, if so, what mitigations are possible to reduce this risk?

i) Were there any risks pre and post birth?

2.1 IM has a history of vulnerability that is relevant as a risk factor to her parenting of Isabella. IM had been known to Central Bedfordshire Council Children Services as a child and a couple of Initial Assessments were undertaken in 2010. She had an Individual Education Plan (IEP) in place while at school. IM was supported by Autism Bedfordshire, Occupational Therapy and Speech and Language Therapy as a child and reported to be a victim of repeated bullying at school and then when she was in college.

2.2 In June 2018, her GP re-referred IM to CAMHS for self-harming and starting to re-exhibit features of obsessive-compulsive disorder (OCD). Due to the lack of any successful telephone contact she was discharged to Bedfordshire Talking Therapies. IM had a telephone triage by Bedfordshire Well-Being service and the decision was made to refer her to her local Community Mental Health Team (CMHT) as one of the exclusion criteria for talking therapies support is self-harming, which IM had done in the past. Her suicidal ideations had also increased.

2.3 In September 2018, IM was taken to Bedford Hospital A&E department by her family as she was highly emotional and anxious. The impression recorded by the clinician was of a young lady who appears to be experiencing an adjustment disorder with the addition of increased emotional difficulties due to diagnosis of dyspraxia, a developmental co-ordination disorder, (this is a common disorder that affects movement and co-ordination.) IM had her first appointment with her local CMHT later that month and she was diagnosed with mixed anxiety and depressive disorder and prescribed anti-depressant medication with a planned review in two months.

2.4 At a review appointment the next year, 2019, a decision was made to refer her for an Autism and an Attention Deficit Hyperactivity Disorder (ADHD) assessment.[1]

2.5 On 9th December 2019, immediately prior to pregnancy, IM was seen in A&E following an overdose of her prescribed medication following an argument with a family member. It is also noted

[1] The Autism Assessment Service sits in the Services for People with a Learning Disability albeit, you don't have to have a learning disability to access the Autism Service. The ADHD Assessment Service sits in the Mental Health Services. Whilst both sit within one directorate across Bedfordshire and Luton, the two services are managed separately. Work is currently being undertaken to reduce barriers in this respect and to look at a Neurodiverse service in its own right which will make the pathway clearer in the future.

that she had self-harmed with a kitchen knife the previous evening, causing superficial cuts to her forearm. Following assessment by the psychiatric liaison service (PLS) provided by East London Foundation Trust (ELFT), she was discharged having been assessed as not requiring any further intervention at that point back to the care of the CMHT.

2.6 During the booking appointment for the pregnancy with Isabella, it was identified that IM suffered with anxiety and depression. She reported that she was not taking her medication at that time due to her pregnancy. There had also been the significant incident where she had attempted suicide by an overdose only a few weeks earlier. It was noted at the time of the booking that IM was in a new relationship of three months with the father (IF) of Isabella. A referral was offered to Mental Health Services but declined by IM, there is no record that this was ever re-offered. There is no record of any attempt to contact ELFT Adult Mental Health Services to discuss IM's- Mental Health history. ELFT provides a perinatal service that provides support to mothers with a diagnosed moderate to severe mental health – given mother's history, specifically her recent suicide attempt, this could have triggered a referral for the perinatal team to consider.

2.7 Taking account of the recent reported overdose, the newly formed relationship, and subsequent pregnancy, this information should have informed a wider risk assessment of IM's vulnerability and the context of the new relationship with IF. It could also be suggested that with the information about her co-habiting with IF, a clear understanding surrounding her housing situation would have also been important. It was recorded, that at the booking appointment, domestic abuse screening questions were completed, and IM stated that there was no domestic abuse.

2.8 The lack of account taken of IM's vulnerability, in this case did not support an effective risk assessment surrounding her needs. During pregnancy, and as part of the risk assessment, this information was not triangulated with other agencies to support the risk assessment or help with an understanding of the family dynamics in preparation for parenthood.

2.9 IM was aged 20 at the time of booking and consideration surrounding her young age as a vulnerability should also have been noted and understood during her midwifery care. This would have provided an opportunity to work with the Mental Health Services and in particular the potential to consult and work with the ELFT perinatal service.

2.10 IM was known to community midwifery services in 2020, who supported her with antenatal and postnatal care for the pregnancy of Isabella. There is reference in the handheld maternity notes that the midwifery service was aware of the overdose in the time leading up to her pregnancy. The midwifery service was also aware of her history of anxiety and depression and that she was medicated until she was advised to discontinue medication on the advice of her GP.

2.11 When the Health Visiting service took over post-natal care, there was no reference of previous maternal mental health history in the maternity discharge summary. If this had been present it would have emphasised the need to review health records prior to the first visit, so obviously this did not take place.

2.12 There was a good exploration of the informal support available to IM from friends and family. The Health Visitor was told it had been a planned pregnancy and Isabella's parents (IM & IF) were living together. There were no financial concerns. At that time there were no housing issues. These are all factors that are seen to reduce risk of harm.

2.13 There were eight contacts made with the family between 22nd of September 2020 and the last contact from the Health Visiting team on the 26th of November 2021. At the new birth visit on 7th of October 2020, IM reported that she did have a history of depression which was well managed. There is no culture of joint visits with the Midwife and Health Visitor to antenatal service users who have a history of vulnerability, for them to assess and agree a care plan. This is a missed opportunity to provide a joined-up care pathway for parents who may have additional needs but do not appear to

meet the thresholds for Children's Social Care. The ELFT panel member for the review considered there to be an opportunity in similar cases for a joint visit with their Perinatal Service and an opportunity for a multi-agency professional discussion including the Perinatal Team, which could have contributed to care planning, as well as maximising the opportunity of contact with IM, when concerns were emerging.

2.14 The review author agrees with this panel members view and feels it highlights this being a missed opportunity period, where the thinking about IM's vulnerabilities as a parent should have equally, if not more importantly, been about her risks to the unborn baby, followed by a post birth analysis of how Isabella's needs and the risks of harm to her, from either her mother-IM - or her mother's inability to safeguard her from harm from others, such as IMB, should have been considered.

2.15 Isabella was brought to the health clinic for her 1-year review when she was 14 months old. This review had been delayed as there had been two previous appointments offered which Isabella had not been brought to. There was no response to the first offer of the development review on the 24th of August 2021. A further appointment was sent for the 21st of October 2021 which Isabella was not taken to. The Cambridgeshire Community Services (CCS) 'Was Not Brought policy' was followed.

2.16 The definition for teenage mothers and young fathers refers to young mothers under 20 and young fathers under 25. *'Teenage parents can be associated with poorer outcomes for their health, education and economic outcomes that affect parents and their child's life chances.'* (Public Health England, 2019.) It is unclear if the family were offered this service-or if it was even available due to the pandemic restrictions. This service is offered by the Midwifery Service. If IM had been seen by a Bedfordshire Hospital she would have been referred to the Under 20's Pregnancy Pathway which has appropriate support.

2.17 When IM had an autism assessment via video link, this turned out to be the first time that ELFT became aware that she had a baby. They had extensive information that they could have shared about IM from their interactions with her over the previous years, in particular, the suicide attempts a year earlier. It is not documented in her CMHT notes that she was pregnant, and it appears that IM did not disclose her pregnancy to the CMHT. If the CMHT had known, they might have considered a referral to Perinatal Services and once discharged, continued to support her alongside system partner agencies if assessed as appropriate to do so.

2.18 The professional at the autism video session could have asked some questions in relation to IM and Isabella's living circumstances to check out how well, or not, she was coping with a newborn baby. Questions could have been asked allowing the practitioner to seek consent to follow up with the GP, CMHT and Health Visitor or for safeguarding to be considered if concerns were apparent. The ELFT IMR author stated after looking at IM's clinical notes that the professional would have seen that she was known to the CMHT and if concerns arose, contact could have been made to see if a duty call could be made to check on her and baby Isabella's wellbeing.

2.19 When the parents separated in April 2023, IF claimed that IM was obstructing his contact with Isabella as she did not feel his flat was suitable for the child to stay with him, stating it was dirty, damp and with mould on the walls. IF told CBC Children's Services that he had been trying to see Isabella, but IM was not prepared to be amicable.

2.20 On the 23rd of May 2023, Biggleswade CMHT sent an email to CBC to inform them that although IM had been discharged from the CMHT in August 2020, she was then open to the Biggleswade ADHD assessment service and was on the waiting list for an ADHD assessment that might lead to a formal diagnosis. The CMHT advised CBC in error, that the ADHD pathway is a health commissioned service that does not include social care provision; therefore, any concerns that IM was experiencing alleged domestic abuse would need to be followed up by the CBC. People on the ADHD waiting list are held on a separate caseload (to manage the waiting list) however, if a person presents with mental health

needs, the CMHT would have considered what, if any, care and support or intervention could be provided to them, including any adult social care related issues. This is clarified later on in the report setting out a different responsibility.

Key Learning

- There is a history of vulnerability for IM- Self harm, suicide ideation, ADHD, depression, anxiety, had an Individual education plan (IEP) with developmental coordination disorder. These vulnerabilities were not taken into account when professionals were considering IM's parenting capacity and risks to Isabella.
- Joint visits via the Midwife and Health Visitor to antenatal service users who have a history of vulnerability, will enable effective assessment and care plan.
- The Under 20's Pregnancy Pathway was not triggered to support effective risk assessment for her parenting and multi-agency sharing of vulnerabilities pre and post birth of Isabella.

ii) Were there any times in the crucial last two or three weeks of Isabella's life where higher quality practice might have saved her life?

2.21 On the 6th of June 2023 Hertfordshire Constabulary received a call from Isabella's maternal grandmother asking for advice and wishing to report her daughter (IM), as a missing person.

2.22 The grandmother expressed concern that her daughter had taken Isabella to Great Yarmouth on the 1st of June by train and was staying in a hotel with her new boyfriend (IMB), he was identified at that time only by his first initial.

2.23 The grandmother was concerned that she had been unable to speak to IM as her daughter's phone was broken. During the Police contact with the grandmother it transpired that IM's sister had spoken to her by a video-call, and had ascertained that she was at a holiday camp with Isabella and IMB. IM indicated that they were safe and well.

2.24 The grandmother was advised that if she was able to ascertain the full details of her daughter's new boyfriend, IMB, that she should contact her host-force area (Bedfordshire Police) and make a Clare's Law request should she have any concerns about him. The family were that concerned for the safety of Isabella and IM that they went to Norfolk to search for them, but they couldn't find them. They told the report author that they also visited the Police Station in Great Yarmouth asking for help to find them but they felt that help wasn't forthcoming, so continued to search by themselves. The lack of contact by IM with her family was considered totally out of character and the information they had heard anecdotally about the new boyfriend IMB worried them greatly.

2.25 The Hertfordshire Police control room determined that this was not a missing persons matter and the report was closed with no further action to be taken. The incident was not cross-referred to Bedfordshire Police in view of there being no obvious or apparent link. The incident was not cross referred to Norfolk, there being no suggestion that it should have been. The review author is of the opinion that contact with both Bedfordshire Police and Norfolk could have been considered, if only for their information.

2.26 While in Norfolk, the family stayed in five different locations. Housing services were involved with them during this time, this is covered later in this report, but as an example, IM sent a text to the Central Bedfordshire Independent Domestic Violence Advisor (IDVA), asking if the IDVA could help her find accommodation in Great Yarmouth. The IDVA advised her that he had already spoken to housing in Great Yarmouth. The call the IDVA was referring to had come from housing on the 9th of June, in Great Yarmouth to discuss the appropriateness of the mother's housing application and wanted the IDVA's opinion. The Duty to Refer protocol should have been initiated at this point where there is a

risk of homelessness.[2] The Duty to Refer guidance puts the duty on specified public authorities to refer service users who they think may be homeless or threatened with homelessness to local authority homelessness/housing options teams.

2.27 Central Bedfordshire alerted Great Yarmouth Housing didn't though refer Isabella to Norfolk County Council Children's Services at this time. Even though abuse and neglect were identified. CBC Children's Services records for this date states, *'I am worried about parents. They are refusing to tell us where they are staying tonight. We know they have no money and no links to the area. We may need Police assistance.'* At this point more information regarding IMB, including his basic details could have been clarified to provide an opportunity to gather all known information, including any Police information, and assess the risks to Isabella at that time. An immediate visit to assess Isabella's presentation and the family relationships and dynamics would have assisted. This is recognised as learning for all agencies, including the option of escalating a review of the responses of other local authorities in the future.

2.28 The family were reported as living in a tent on the beach by members of the public. In response to these concerns, on the 16th of June 2023, a Police Officer and other officers from Norfolk Constabulary visited them on the beach. The interaction was captured on body worn video. The officers' main reason for the visit was the primary concerns of inadequate food, water, and shelter. The officer observed that there was some food and water, but the water was certainly insufficient for the family's needs as it was a very hot day (over 30 degrees). Although the officer was not called to attend because of concerns of abuse towards Isabella, she was observed by the officer playing in the sand, and her face and hands (which were on show) were unmarked. The Police Officer considered taking Isabella into Police Protection in relation to the food, water, and shelter concerns, they also stated that Isabella would have been at risk if they remained in the tent, however they did not fully conceptualise the level of neglect that was apparent. The officer contacted IM's domestic abuse worker in CBC who confirmed that she had been offered emergency accommodation but had refused as the three of them couldn't be placed together, she didn't want to return to Central Bedfordshire due to fleeing alleged domestic abuse from IF. Following this interaction the family were provided with temporary accommodation over the weekend in Norfolk. The Police Officer submitted a Safeguarding Referral Form to Norfolk's Emergency Duty Team (EDT) inbox. The report stated that Isabella only had a few nappies, but her mother said she was potty training (despite there being no potty) and that there was no known Police history.

2.29 The Police report states that IM was being supported by her 'domestic abuse worker,' which was not in fact the case and has since proved misleading as this was someone acting as a concerned citizen. Her telephone number was provided as the 'main professional' to contact. Police report states that discussions would take place between 'IM's domestic abuse worker and the family moving forward.' This further supported the view that Isabella had professional support around her, which she did not. The CBC IDVA called this concerned citizen, thinking they were the allocated IDVA, and explained that if IM does not find somewhere suitable to stay before 5pm on the 19th of June, they presumed the Police would look to use their safeguarding powers to remove the child and place her in the care of her maternal grandmother. The CBC IDVA agreed that she would copy in the concerned citizen to emails, so that she could liaise with CBC Children's Services manager direct.

2.30 The emergency housing provided over the weekend had been arranged by this local concerned citizen. This concerned citizen, in her professional role was employed as a housing domestic abuse worker, this though was not the capacity she was working in for IW and her family. She was in fact called in to help by one of her relatives and arranged accommodation for the family at a holiday park where they were able to stay until more permanent accommodation was secured. The concerned citizen later stated that she was anxious of the controlling behaviours displayed by IMB and did offer

[2] A guide to the duty to refer - GOV.UK

to try and support Isabella and IM getting space in a refuge, but this was declined. She liaised with her team manager to advise what actions she had taken out of hours, but the case was never allocated to her in a professional capacity. The Police report included the name of IMB, but not IM, although two mobile telephone numbers were provided. The report did not include the full name of the concerned citizen, but as stated, a contact telephone number was provided. The concerned citizen gave her work contact details to the family.

2.31 The next day (a Saturday), the 17th of June 2023, an EDT Contact Record was raised with the concern of 'homelessness'. The EDT Service Manager noted the absence of any of the adults' full details within the Police report. He attempted to contact both the mobile phone numbers provided for IM and IMB and also the number of the concerned citizen who they thought was acting as a domestic abuse worker – with no answer. The Service Manager was curious about the concerned citizen, as the facts surrounding her role were not clear. In the analysis section of the EDT record, the Service Manager noted that there was limited information to act upon in the Police report, EDT considered the fact that the Police information did not trigger the threshold for a Strategy Discussion, nor did the police feel it necessary to arrest the adults or initiate Police Protection for Isabella, which must have meant that there were no immediate safeguarding risks that required intervention. However, professionals did not fully consider the level of neglect and the failure to meet Isabella's basic needs as meeting the threshold for immediate intervention. The Service Manager understood from the Police that the family had secured accommodation over the weekend, he therefore assessed and concluded that there was no immediate safeguarding action that needed to be taken, although he noted that safeguarding risks would need to be further explored.

2.32 On that basis, the referral was passed to onto the Children's Advice and Duty Service (CADS) to be picked up by a Consultant Social Worker on the Monday 19th of June 2023. The Consultant Social Worker in CADS noted that they also struggle to understand the concerned citizen's role in Isabella's life even after talking to them on the phone.

2.33 Overall, despite there being some uncertainty and curiosity about the concerned citizen's role in the case, there was too much weight put on the providence of her being a professional domestic abuse worker. Explaining their role as a domestic abuse worker led professionals to think she was acting in a professional capacity supporting the family, rather than being a concerned citizen attempting to help a family in need. Police, in fact, in their report, refer to her as IM's domestic abuse worker who supported the family to access emergency temporary accommodation and that discussions would take place between the worker and the family moving forward. This further supported the view that Isabella had professional support around her, which she did not.

2.34 The Central Bedfordshire Council (CBC) IDVA called this concerned citizen, thinking they were the allocated IDVA, and explained that if IM does not find somewhere suitable to stay before 5pm on the 19th of June, they presumed the police would look to use their safeguarding powers to remove the child and place her in the care of her maternal grandmother. The CBC IDVA agreed that she would copy in the concerned citizen to emails, so that she could liaise with CBC Children's Services manager direct.

2.35 There is no doubt that this was a crucial time in Isabella's life to intervene. When both sets of the family met with the report author they were keen to stress that in their view this was the key moment that an intervention should have taken place. The response to a family who had moved geographical areas, with a small child living on the beach, at that time of year, in those conditions, Isabella's lived experiences and the subsequent decision making and escalation of this critical phase in Isabella's life, was insufficient. Learning from this should include attention to the supervision and management of practitioners when triangulating key pieces of information. For example, we know now the information was readily available at the time, including witnesses at the criminal trial stating seeing bruising and non-accidental injuries to Isabella, the pathology also confirms serious injuries at this

time were evident and the concerned citizen reporting to a panel member Isabella's 'over-quiet' demeanour and that she looked 'pale' and 'undernourished.'

2.36 Following a conversation with IM and having her hang up on them, it was apparent to the CBC Team Manager that IM was not presenting as she had previously, based on the recorded information held, and decisions made by IM, were not prioritising Isabella's needs. In particular, previous discussions with CBC by IM about housing needs had seen IM describing that she wanted to secure accommodation for her and Isabella that was accessible to Isabella's nursery. This had changed, IM was now prioritising the needs of IMB over Isabella (IM agreed this to be true at the criminal trial). Due to the immediate assessment regarding the changing verbal presentation and responses of IM and IMB and the emergency of the situation, a CBC Team Manager emailed Norfolk CADS at 16.54 on the 19th of June stating that she was concerned about the situation; and felt that Police assistance may be required later that evening, and that Isabella may need to be admitted into care.

2.37 CBC could have raised an escalation to Norfolk CADs senior management at this point, or to the Police requesting an immediate visit, and a Strategy Discussion to resolve responsibility based on the level of concerns regarding Isabella. The completion of a Strategy Discussion would have provided an opportunity to gather all known information, including any Police information, and assess the risks to Isabella at that time, and, as importantly, an immediate visit to assess Isabella's presentation and the family relationships and dynamics. IMB, in the professionals' view was controlling the situation, this CBC considered concerning. Norfolk CADS had made the decision to undertake a Social Work assessment however by the time, the family had moved on to Suffolk.

2.38 On 20th of June 2023, Central Bedfordshire Council (CBC) Children's Services made a referral to Suffolk Children and Young People Services (CYPS) as the family had re-located to Suffolk and needed support. During the email exchanges between the two authorities, CBC advised they had reviewed Suffolk's Threshold Matrix and that in their opinion the concerns met a threshold of Section 47 Children Act 1989[3], as in their view Isabella was at risk of significant harm and not appropriately protecting Isabella. IMB was unknown and was deemed as controlling by both Great Yarmouth and Central Bedfordshire housing; and IM was vulnerable as an alleged victim of domestic abuse (this she has admitted at the criminal trial was untrue, but that she was using it as her means to get help). To support their view, CBC records from the time state, '*Risks of significant harm – the family are at risk of being street homeless, they have no access to finances and there are concerns that they have not been able to act protectively to safeguard the child in turning down two refuge placements. Mother appears to prioritise her partner who she has recently stated is now the father of her child. They have not been open with agencies and professionals regarding their circumstances and left the area without a plan in place to safeguard the child. There were concerns that police action was required yesterday as mother and her partner were not working with services to find a solution and the child had nowhere safe to go. I have referred to your safeguarding document and I believe threshold is met for Section 47 on the basis of imminent homelessness concerns and concerns regarding mother's capacity to protect and prioritise the needs of the child. Mother's partner is a significant unknown and concerns have been raised by Great Yarmouth housing and Central Bedfordshire Housing that he has presented as controlling on phone calls and may be influencing the decisions mother is making regarding housing. Mother is vulnerable herself as a previous victim of domestic abuse.'*

2.39 Ipswich Borough Council's housing department also made a referral to Suffolk CYPS on 21st of June 2023, as IMB described the domestic abuse from IF towards IM, (now known to be untrue).

2.40 Following these two referrals, Isabella was made subject to a Multi-Agency Safeguarding Hub (MASH) assessment by Suffolk CYPS. Attempts were made by them, to speak with IM via telephone, but could not speak to her. IMB was spoken to. Suffolk MASH liaised with both Norfolk and CBC

[3] Section 47 Children's Act 1989 where the Local Authority have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm.

Children's Services and Suffolk made the decision that the referral and information reached the threshold for a Social Work assessment.

2.41 The CBC Access and Referral Hub offered to be a part of any Strategy Discussion to discuss the risks. This was an appropriate request and if it took place, risk would have been discussed and a decision made at the appropriate threshold. CBC could have considered escalating the decision which Suffolk took to assess under Section 17[4] instead of a Section 47 Enquiry. A Section 47 visit, especially if a joint visit with the Police, may have disrupted the behaviour of the adults IM and IMB, and she may have been removed from their care at that stage. Suffolk's view in relation to this is different: they did not at the time, and upon their later in-depth review of the Threshold Matrix agree with the opinion that the information known at the time met a threshold for a Strategy Discussion leading to consideration of a Section 47 Enquiry. It is accepted by Suffolk however, that they should have taken up the offer of a conversation with CBC to discuss. The most significant concern presented to Suffolk in their view, was homelessness and that this had been addressed. The other concerns as they understood them, were not suggesting the threshold to suspect significant harm - but that the concerns could be explored and addressed through a Section 17 assessment. Suffolk CYPS and Suffolk Police have, since the death of Isabella, held a learning conversation. Through reviewing the information known at the time Police have advised there were no grounds for Police involvement. Suffolk Police have re-iterated to the review author that this is still their opinion.

2.42 Suffolk MASH processed the case in a timely manner, concluding that an assessment under Section 17 was appropriate. The case was passed to the front-line team on the 23rd of June, again in line with procedures and a management decision to progress the assessment was entered by the Child in Need Team on the 26th of June. The first attempt to contact IM by telephone was not until Wednesday 28th, an attempt was also made on Thursday the 29th of June. Isabella was found deceased on Friday 30th of June. This meant, Suffolk CYPS were aware of Isabella living in their area for nine days with no contact having been successful with IM and no arrangement in place to visit Isabella.

2.43 Since Isabella's murder, Suffolk CYPS immediately reviewed its Social Work Assessment Framework tightening the actions to be taken at the point of a newly allocated assessment. This was followed up with learning sessions for frontline managers and practitioners with examples of good practice being shared, including guidance for Practice Managers and Consultant Social Workers to ensure attempts to contact the family commence no later than one day after the case is passed to the team. If contact is not successful, then this will now be escalated to more senior Social Workers for consideration. Regular audits have been taken since that time that show evidence of improved practice in this area.

2.44 The classification of referrals as 'domestic abuse' and 'homelessness' should have been more focused on Isabella's lived experience, including consideration of the impact of neglect. This would have required a deeper exploration of the family's known history to services to risk assess the immediate situation, professional curiosity about the fact that the family were found camping on the beach in Great Yarmouth and had moved around, this should have alerted the various agencies as to concerns over the parenting of Isabella.

2.45 In addition it could be argued that at the point that the maternal grandmother attempted to make a missing person's report concerning Isabella and IM, this is both to Hertfordshire Police and then Norfolk Police when she went into a Police Station there, that the wider implications concerning the safeguarding of Isabella were not fully considered on their own merits. Had the full details of IMB emerged at that point, bearing in mind that his local and PNC record had no warning markers for him that were indicative of his risk of harm to Isabella, but his mental health records would have raised serious concerns. ELFT is a multi-agency partner and could have been contacted to request any

[4] Section 17 Children'[s Act 1989 is to safeguard and promote the welfare of children within their area who are in need.

relevant information relating to Isabella's safety from a mental health perspective, and they stated that they would have attended any Strategy Discussions as required to contribute to the risk discussions.

2.46 When the referral from Ipswich Borough Council referenced 'concerns were raised by hostel staff,' good practice might have been to make direct contact with the hostel to better understand the nature of those concerns and to also ask for a knock on the door to alert the family that Suffolk CYPS were trying to reach them (they had been aware of the referral being made.) Arrangements could also have been made to cold call to catch the family at home. It meant that because no other agency had eyes on Isabella, her exact circumstances and the level of risk she was exposed to, was unknown and unassessed. There is learning when no one else might be seeing the child, to expedite a visit, as in this case, for a toddler who wasn't attending a nursery setting, she wasn't being seen by any other agency, and it wasn't checked with the hostel if they had seen her with IM and IMB. This is learning that Suffolk Children Services have already put in place but of note for wider learning.

Key Learning

- When the connected adults reported Isabella and IM missing the information wasn't shared with Bedfordshire Police and Norfolk Police which would have allowed further information to be sought about the risks to Isabella.
- The neglect of Isabella; living in the tent with her basic needs not being met, and IM prioritising IMB over Isabella went unidentified and should have increased the concerns.
- The bruising and non-accidental injuries seen by witnesses were not referred into Children's Services and triangulated by professionals.
- Too much weight was put on IM fleeing the alleged domestic abuse which diverted professionals from understanding the risks IM and IMB posed to Isabella.
- A barrier to decision making was the lack of details, history and knowledge of IMB, meaning no one professional had a full understanding of the risks he posed.
- The reported and documented concerns of the Social Worker and Team Manager from CBC, were not heard or acted upon. At the same time, the lack of escalation is evident throughout this period and didn't assist prioritising a professional seeing Isabella.
- The housing department did not follow up with a safeguarding referral to Children's Services where abuse and neglect were identified.
- Concerns decreased because it was thought that other professionals were providing a service when they were not acting in a professional capacity.
- Threshold was not considered to have been met for a multiagency Strategy Discussion, meaning the opportunity to coordinate a safeguarding response was lost when it shouldn't have been.

iii) Was Isabella's invisibility partly due to the speed with which the family moved around and, if so, what mitigations are possible to reduce this risk?

2.47 The family of Isabella described to the report author when they met him, how Isabella loved Paw Patrol. When IM found out she was expecting a child, she was excited, she was a nursery nurse and she loved children. IM was very prepared and was in their opinion a very good mum to Isabella up until the beginning of June 2023. Motherhood seemed to come naturally to IM and her family were all very impressed at how she cared for Isabella, she was always thinking about Isabella's needs, diet, nutrition, her development etc.

2.48 The maternal family stated to the report author that Isabella adored her mother and would always want to cuddle her - if she was sick, she would want to be with IM. When she was ill IM would seek appropriate help and give her Calpol and medicine for example. Isabella is described as an adventurous and fearless little girl - full of life, excitable and cheerful but well behaved. The family

including IF have lots of photos of birthday parties, Christmas, and family trips (IM, IF and Isabella) to the zoo and park.

2.49 There is information within the IMRs that help the report author and the panel relating to Isabella's lived experience or where her voice was sought. This in particular applies to the health information during the first two years of Isabella's life, for example, Isabella did achieve her development milestones. This voice and lived experience did deteriorate from the time when IM and IF separated.

2.50 The three alleged domestic abuse incidents that were attended by Bedfordshire Police do not in the police reports describe the lived experience or the voice of Isabella. Bedfordshire Police do though provide good and clear guidance to officers to ensure that the voice of the child is captured using primarily the AWARE principles (Appearance, Words, Activity, Relationships, Environment). The force embraces the opportunities for officers to seek the perspective of the child at every opportunity to maximise safeguarding opportunities. Officers will be mindful of both the age of the child and any effect that this may have to noticeably young children. Isabella was 2.9 years of age at this time.

2.51 The Police Officer that saw her on the beach in Norfolk describes her as 'happy' and 'healthy' and whilst Isabella wasn't wearing a sun hat, she was described as 'covered elsewhere.' Those descriptors formed part of the Police and Norfolk EDTs' risk assessments and influenced threshold decisions.

2.52 The Police acknowledged that the situation was not ideal for Isabella, temperatures were extremely high, well above 30c and their own assessment was that there was not enough food, water, nappies, and the only shelter the family had, was the tent. However, this did not lead to a Strategy Discussion because it was deemed the family had been helped from the 'domestic abuse worker' (concerned citizen) and members of the public and the family had been offered and were taking up emergency temporary accommodation in Norfolk over the weekend.

2.53 This concerned citizen, did in fact do a lot for the family, displaying care, interest, and kindness. When she spoke to a member of this CSPR panel she, on reflection at that point, described Isabella as being very quiet; she looked pale and undernourished. It was extremely hot, but Isabella when she first saw her was wearing a big winter coat, when she had contact with Isabella over a couple of days she could not see her arms or legs. Isabella presented as happy when in the holiday park but cried when she was made to get on the train to Ipswich later on the Monday afternoon, the 19th of June.

2.54 No other professional saw Isabella in person to assess her needs. Norfolk operational Social Work team were going to assess Isabella under Section 17, The family were on their way to Suffolk before this happened. Other than the Police, no other professional saw Isabella in person to assess her needs before they moved on to Suffolk.

2.55 Once the case had been transferred to the social work team in Suffolk. There was a focus upon safety planning that needed to be in place in relation to the alleged domestic abuse, this was not unreasonable but there was no mention of when Isabella needed to be seen by. This practice has now been addressed through updating the Suffolk Social Work Assessment Framework guidance.

2.56 As has already been mentioned in this report, Suffolk CYPS were aware of Isabella for at least nine days without being able to make contact with IM and with no plan of next steps to see Isabella, which has now been addressed by a change in procedures and staff training.

2.57 Whilst staying at the hostel in Suffolk, the hostel staff, on reflection, never remember seeing Isabella out of her buggy. It must be highlighted that it is estimated that Isabella, when found, had been dead for approximately three days.

2.58 In 2011 Ofsted published a thematic report, 'The voice of the child: Learning from Serious Case Reviews.' There were five main messages with regard to the voice of the child within this report.

• In too many cases the child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings

• Agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute

• Parents and carers prevented professionals from seeing and listening to the child

• Practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child.

• Agencies did not interpret their findings well enough to protect the child[5].

2.59 A number of the points mentioned in this Ofsted thematic are also key learning for this CSPR as this is clearly what happened for Isabella.

Key Learning

- The change in Isabella's visibility to family members and professionals from the beginning of June 2023, should have altered professionals' decision making, as no one was seeing her and Isabella was becoming invisible.
- When the Police visited during the previous alleged domestic abuse incidents or the Police visit to the beach, there is no record of seeing the situation through the lived experience or voice of Isabella, which was therefore a barrier to other agencies on receipt of the information for their decision making.
- A clear system learning is the lack of clarity of the concerned citizens role and the over reliance of them acting in a professional capacity when they weren't.
- The learning that re-occurs constantly in safeguarding children cases is that of professionals focussing on the needs of the adults and losing sight of the children's needs, as in the case of Isabella, a focus on IM fleeing from alleged DA, which is now known to have been untrue.
- Framing the concerns as homelessness and alleged domestic abuse caused professionals to lose sight of the risks to Isabella and her voice was not sought or heard.
- No professional properly saw Isabella and sought out her lived experience or her voice.

3.0 The unknown/grey area about IMB and the risks he posed.

3.1 There was a lot of information available within agency records about IMB that had it been shared, or even enquired about, would have led practitioners to believe that Isabella was likely to be at significant risk from him. The ELFT panel member felt they could also have been contacted to share the relevant information that they had on him and would have participated in any professional discussions.

3.2 There are education records for IMB from his schools, both of them in Central Bedfordshire, between 2012-2015. These show incidents including theft, physical assaults towards adults and other pupils, disruptive behaviour and verbal/threatening behaviour over that period which resulted in exclusion. He had a Special Educational Needs Assessment in February 2015 (age 14) which found that he:

- experienced difficulties in managing and modifying his behaviour
- was unable to manage alternative views and social interaction

[5] report OFSTED. (2011). The voice of the child: Learning from Serious Case Reviews. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/526981/The_voice_of_the_child.pdf.

- would break into a spontaneous rage if encountering conflicting opinions
- was unable to talk about emotions in any but the most basic terms, finding it difficult to identify from photos of a variety of subtle facial expressions how another person might be feeling.

3.3 The school report concluded that IMB's limited understanding of his own, and other people's emotions undermined his ability to communicate rationally and purposefully with others. He also had a formal diagnosis of ADHD and was on medication.

3.4 IMB came to the attention of the local Community Mental Health Team (CMHT) in September 2020, when his GP referred him to re-start ADHD medication. He was diagnosed with ADHD & Oppositional Defiant Disorder[6] as a child. He had an initial telephone appointment on 1st of October 2020, his risk was assessed as moderate risk to others (has the urge to hit out), moderate to high from injuries caused by his angry outbursts (broken his knuckle in the previous week when hitting objects at his mother's house), and the risk of committing a criminal offence was assessed as high (two pending court cases). He reported hearing voices and when going past parked cars seeing dead bodies. He also disclosed self-harm and the use of cannabis on a daily basis. IMB reported in his appointment that anger was his biggest problem. He was assessed as high risk, he reported that he was having angry outbursts, which warranted a safeguarding concern which needed to be shared and that could have triggered a multi-agency response which could have led to an assessment to support him and manage the risk posed by him to both himself and others.

3.5 Having received a Police referral in December 2022, the decision was made at the CMHT triage meeting not to assess, but to instead, refer IMB to the Local Authority Adult Social Care Team to undertake a Care Act 2014 Assessment. The Safeguarding Adults Team at Central Bedfordshire Council did not agree and responded to the request suggesting that it would be appropriate for ELFT to complete the Care Act Assessment due to his severe anxiety associated with his ADHD and Autism. The Local Authority also stated that if, and when, an assessment has been completed, and if IMB did not meet the criteria for ELFT-CMHT involvement, the information could be passed on to Central Bedfordshire Council so a relevant team could be requested to act.

3.6 On the 23rd of December 2022 at a CMHT triage meeting, the contact from Central Bedfordshire Council was discussed. It was agreed that it was not appropriate for secondary care. The Primary Care Link Worker agreed to make contact and consider if a Care Act 2014 assessment was indicated.

3.7 On the 19th of January 2023, the referral was closed as the Primary Care Link Worker was unable to contact IMB after multiple attempts. There is no evidence that this information was passed back to Central Bedfordshire Council for them to follow up, as was suggested by the Local Authority Adult Social Care team. The IMR author is of the view that the CMHT should have accepted the Police referral in December 2022, and agrees with Central Bedfordshire Council's view that it would be appropriate for East London NHS Foundation Trust (ELFT) to complete the Care Act Assessment due to his severe anxiety associated with his ADHD and Autism.

3.8 The Police referral, referred to in the above section, is a domestic abuse incident. Officers were called to attend a location that is CBC Housing temporary accommodation and is used to house homeless households. It is a hostel-style accommodation. IMB, with his then partner, were the occupants of one of the flats and admitted that they had been arguing and screaming at each other because the partner was having difficulty coping with IMB's mental health. There was no reported injury to either party and neither of them would consent to a Domestic Abuse Risk Assessment (DARA) being completed. The conditions within the flat were described as being 'filthy' and indicative of self-neglect. The then partner was the designated tenant of the accommodation.

[6] Oppositional defiant disorder is a type of disruptive behaviour disorder in which children frequently defy authority with hostility, leading to serious disturbances in their daily life.

3.9 Adult at risk referrals were made for both persons. IMB informed the reporting officers that he suffered from autism and had ADHD and struggled without the support of his then partner. The adult at risk referrals were shared with Adult Social Care, primarily in respect of the extremely poor living conditions and lack of personal care. The Domestic Abuse Risk Assessment (DARA) of a medium risk was determined by a supervisory officer on the basis that both declined to support the DARA risk assessment process. No further action was taken and no further enquires were made. Had the outcome of the DARA been shared with CBC Housing (who were accommodating the individual/s at the time) protective actions could have been taken. With the benefit of hindsight, it is difficult to say exactly what actions would have occurred, but it is possible that housing wouldn't have evicted the household following this incident and would have taken steps to protect IMB's then partner by referring her to specialist Domestic Abuse Housing Workers. Discussions could also have taken place about removing IMB from the then partner's application and offering her an alternative temporary accommodation in a different location or to find a space in a women's refuge. Or, if she wished to remain in the relationship, they could have been more closely monitored.

3.10 The following information was not known before the murder of Isabella but is of relevance to both the homicide investigation and for learning from this review as it shows IMB's controlling and coercive behaviour and of course was known at the time if the information was sought. When the previous partner was contacted by Suffolk Police, as part of the homicide investigation, after an initial reluctance to disclose, the previous partner became confident to speak with officers and disclosed that she was subjected to domestic abuse by IMB to the extent that he controlled her movements, finances and subjected her to a number of assaults, threats and, on one occasion, strangulation. This was over a period of some ten months duration.

3.11 IMB cut off this previous partner from her family and friends and employment which had a consequential effect on their income and home environment and her mental health.

3.12 The criminal investigation into the death of Isabella has determined that IM was free to go as and when she wished and feel in their view that IM was not being coerced or controlled by IMB. However, professionals have recorded, and in hindsight suspected that IMB was showing signs of this coercion and control to IM during the month of June 2023 until the time of Isabella's murder. Communication, in the main, for professional agencies was directed through him, and his telephone number was used as the main contact point, without effective professional curiosity about his level of responsibility and the safety of Isabella. This is a sophisticated level of coercive control by IMB towards IM.

3.13 In May 2023, IM disclosed to CBC Housing Officer that she had a new partner, there are no records that the housing officer collected details of the boyfriend. Furthermore, IM indicated that her new partner was a protective factor in respect of her mental health. This could not be explored further by the CMHT as the team declined the referral received in May 2023 in respect of alleged domestic abuse being reported by IM's neighbour. The overall absence of routine enquiry when IM also discussed her living arrangements with the CMHT provided a lost opportunity in being able to identify her new boyfriend and check if services had been in contact with him. The information provided in his clinical notes would have provided context and risk and would have been a trigger for the CMHT to call a multi-agency meeting to review the whole situation and agree next steps.

3.14 When IMB's surname was passed to CBC's Children's Services by Great Yarmouth Borough Housing, it was not correctly spelt. Learning from this example highlights the need for correct information to be collated and shared in writing, to ensure that appropriate background checks are completed. Agency checks should include Housing, Police, and Primary Health Services. In Suffolk Primary health checks are carried out for the relevant children but not for parents/carers at the initial threshold decision stage. These will be carried out if found to be necessary and appropriate during the Social Work assessment.

3.15 The national CSPR panel report (2021), "The Myth of Invisible Men"[7], has real relevance of learning for this review. IMB fits so much of the below comments and behaviours and is information that was known to agencies:

> *'limited coping skills and problems with anger and a low frustration tolerance. These factors and experiences coalesced to create behaviour that was very dangerous to the safety and wellbeing of the babies for whom they were caring.'*
>
> *'In the review's fieldwork, many of the men were found to have had some degree of mental ill health. They may not have been diagnosed nor met a medical definition of mental illness but they nevertheless had histories of diagnosed attention deficit hyperactivity disorder (ADHD), anger management issues, anxiety and depression.'*
>
> *'They might include, for example, knowledge about a man with a mental health problem, known to have anger management issues or poor emotional regulation, forming a new relationship where there are children in the household.'*

3.16 A further area of learning is to ensure that when partners were mentioned in assessments that the name of the partner is always documented, this did not always happen for IMB. Furthermore, when the client talks about friends, family or partners, routine enquiry should involve asking and recording the names of the key individuals involved in a person's life and care, this was not explored in any depth in this case.

Key Learning

- There was information available in agency records relating to the risks that IMB would have posed to others. They would have, if sought/shared, concerned professionals greatly for him to be in a relationship with children present in the household.
- The lessons from the National Panels report (2021) 'The myth of invisible men' should be understood by all professionals as the lessons equally apply to the risks of IMB towards Isabella and also IM.
- Professionals should always record full details of people living in households with children.

4.0 Response to alleged domestic abuse with children in the household

4.1 There are no reports of domestic abuse incidents between IM and IF whilst they lived together. However, in April 2023 the couple separated and reports from neighbours reported that they heard shouting and screaming between them while Isabella was present.

4.2 In a very short period of time following the separation, domestic abuse reports between the two parents began. The Police IMR author has examined three key incidents that were reported to Bedfordshire Police during April and May 2023. The first of these was on the 25th of April 2023. IM attended the property that she and IF used to share to collect Isabella and a verbal argument ensued. During the altercation, IM is the aggressor and is alleged to have slapped IF around the face once, no injury resulted but the assault and argument took place in the sight and hearing of Isabella. IF declined any action being taken by the Police against the mother and declined to complete the DARA question set and the reporting officer identified the risk as medium.

4.3 A counter allegation was then made by IM that she had been physically pushed by IF during the same incident (IM has since said this is untrue). She also declined any formal action to be taken by the Police. No child protection referral was raised by the attending officers, even though Isabella was present. The Public Protection Unit (PPU) Hub reviewed the crime reports and no referrals were made

[7] The Child Safeguarding Practice Review Panel (September 2021) "The Myth of Invisible Men" Safeguarding children under 1 from non-accidental injury caused by male carers. DfE London.

to partner agencies concerning the presence of the child as, in their view, the threshold for referral was not met.

4.4 On the evening of the 7th of May 2023, IF approached officers on patrol claiming that IM was at home, caring for Isabella, but was intoxicated. Officers attended the home address promptly. On arrival, IM was found to be alone with Isabella who was asleep, there was no sign of IM consuming or having consumed any alcohol. The officers assessed the circumstances and were satisfied that there was no risk to the child. The officers completed a child risk assessment, graded as standard, which was later triaged by the Bedfordshire Police Public Protection Unit and shared with CBC Children's Social Care.

4.5 Bedfordshire Police were called to an incident at the flat that they used to share on the 14th of May 2023 when the mother arrived to collect Isabella and an argument broke out. IF brought out a toy gun from a box behind the sofa to show his brother, who was also present. IF was arguing with IM while he was holding Isabella. IM panicked and the Police were called.

4.6 Police attended and the gun was inspected and deemed to be a pellet pistol, which IF was allowed to keep. Safety advice was given. The officers attending confirmed that Isabella had been present at the time of the confrontation between her parents, and although there was no apparent immediate concern of risk or harm to the child, a referral to Children's Social Care given Isabella was present and impacted should have been considered. A DARA risk assessment identified the risk to IM as medium, on the basis of the presence of the child being at the centre of the incident. The background to this incident appears to be that IM was preventing IF from seeing his child and he alleged that IM was heavily dependent on alcohol, although the attending and reporting officer did not suspect any intoxication signs/symptoms being present. The Police's response was in line with policy and practice and the information gathered was considered comprehensive.

4.7 Given the child was only two years old, the voice of the child was not specifically referenced. As already highlighted earlier in this report, Bedfordshire Police do have clear guidance to officers to ensure that the voice of the child is captured. There is no record of this having been done on this, or the two previous occasions when officers attended.

4.8 The Bedfordshire Police Public Protection Unit (PPU) made no further observations following triage and the child risk assessment was shared with CBC Children's Services several days following on from the initial report being raised. No further action was taken by Bedfordshire Police.

4.9 Following the final domestic abuse incident on Monday the 15th of May, when IM attended her workplace, she requested to have a meeting with the manager. During the meeting IM disclosed that over the weekend she had had an argument with IF. She confirmed that they were safe and staying at her parents' house and that Children's Services were involved. Although complaining of a back injury and contacting her GP, IM did not have any visual injuries and did not seem overwhelmed or distressed when sharing the information. Support was offered by the manager. IM wanted to stay at work, and she felt fit to work on that day.

4.11 CBC Housing were also involved with IM at this time as she was seeking alternative accommodation and had told them that this was because she was subjected to domestic abuse (IM has admitted was untrue.) There is no record that a DASH risk assessment was completed by housing officers, or that they looked to obtain this from other agencies such as CBC Children's Services or the Police for a DASH. This was not in line with CBC Housing current procedures. However, IM's disclosure of alleged domestic abuse was taken seriously, and action was taken to offer her 'safe' accommodation so that she did not have to return to her alleged perpetrator.

4.12 IF reported concerns to CBC Children's Services in May 2023 as IM was not allowing him contact with Isabella. IM was subsequently contacted by CBC Children's Services, and she advised that IF was calling her place of work, persistently texting her, and also her mother and sister, saying he will attend

maternal grandmother's house where they are temporarily staying to allegedly remove Isabella. IM said she did not feel safe and said she would consider moving out of the area to keep herself and Isabella safe from IF.

4.13 An IDVA became involved with IM following a referral from CBC Children's Services outlining concerns of the alleged domestic abuse to her from IF. At the time of this referral, it was noted they had been separated for a month. Incidents were noted as verbal and were in connection with child contact arrangements, however, IM had disclosed other types of abuse including physical and coercive control, all in the presence of Isabella (again, this IM has stated at the criminal trial was untrue). Following receipt of the referral, IM emailed into the IDVA service inbox outlining her current situation and concerns for her daughter highlighting the risks from IF.

4.14 An initial call was made by the IDVA to IM who accepted support, but it was explained to her that there was currently a waiting list and explored if there were any urgent needs. IM outlined her current situation and that she was currently staying with her family. IM said she is currently open to Social Care, following her interactions with police over the toy pistol. IF has also made allegations that she is neglectful and misuses alcohol.

4.15 After making this initial contact, an IDVA was allocated to the case on 22nd of May. A call was made to IM which was unsuccessful, followed up by text conversation. At this time she was in emergency temporary accommodation from the previous night and was currently waiting for an update to see if she could still access this as she had to leave the accommodation at 10.00 that morning. She wanted to stay another night as her own mother (Isabella's maternal grandmother) didn't want her at her home at this time.

4.16 During the time this case was open the contact with IM seems to have been somewhat sporadic and she then moved from Bedfordshire to Norfolk, which was out of the remit for Bedfordshire IDVA support. IM then did not return to Central Bedfordshire and the case was closed to the IDVA service on the 27th of June 2023.

4.17 As highlighted already in this section at the criminal trial IM admitted that there was no domestic abuse between her and IF. When she stated there was, she had made this falsehood up, in order to assist herself in her housing situation and in her pleas for assistance.

4.18 As already mentioned in the previous section (the unknown/grey area IMB, and the risks he posed,) there was also known domestic abuse involved in the relationship between IMB where he was a perpetrator to his previous partner, some of which was known to agencies, and more information that came to light following the murder of Isabella.

4.19 It is important to learn from this case and consider the impact on children in homes where there is domestic abuse and/ or coercive control. The Domestic Abuse Act 2021 sets out that children are victims of domestic abuse that is perpetrated against their parent or carer. Katz (2016) in her article about children's experiences of coercive control states: *'Children in coercive control-based domestic violence contexts may live with narrow space for action, reduced 'voice' within the family, disempowerment and erosion of their confidence'*[8].

4.20 When Isabella, IM and IMB, went to Norfolk and their funds had run out they approached the local council to provide accommodation, with the mother citing that they were fleeing domestic abuse. Great Yarmouth Borough Council appointed a Domestic Abuse Adviser at the earliest stage in the process. The advisor offered to source a refuge but this was refused by IM due to her wanting IMB to be with her, which was not possible. Great Yarmouth Borough Council also liaised with the Bedfordshire IDVA and discussed the DASH assessments but did not initiate a safeguarding referral

[8] Katz E (2016) Beyond the physical incident model: how children living with domestic violence are harmed by and resist regimes of coercive control. Child abuse review volume 25 46-59 (2016)

where neglect and abuse is suspected. Agencies should have been more concerned about this fact and more weight should have been given to IM's preparedness to have Isabella homeless rather than be without IMB. IM at the criminal trial readily admitted that she was prioritising her relationship with IMB to the detriment to Isabella. This was also an opportunity for the DA advisor to try and find out more information about IMB and possibly speak to IM about Clare's law.

4.21 After the police officer found them sleeping rough in a tent on the beach, the full extent, including the details of the family's history regarding domestic abuse was not understood. This was not within the Police report to EDT (some details of IMB were included,) Norfolk CADS did information gathering work, there were direct conversations with IM and IMB and there was communication between Norfolk CADS and CBC staff. It has already been established that the role of the concerned citizen, described as IMs' domestic abuse worker misled professional decision making.

4.22 Specific details of who might have been a risk factor, and/or a chronology of what had occurred in any of these two adults (IM and IMB) past or present, were not shared or explored in full by any of the professionals involved.

4.23 The Norfolk CADS Consultant Social Worker appeared to have had the most communication with IMB, which took place on the 19th of June 2023. They have on reflection as part of the review process described his demeanour on the telephone as 'intentionally fast paced,' 'always appeared to be going somewhere' and that they 'couldn't make sense of his intentions.' The Social Worker reflected that their interaction with IMB, seemed 'too good to be true.' The Social Worker was curious about whether he was coercive, she sensed he was charming when working with professionals. The Social Worker was clear that their focus was on getting Isabella to a place of safety and were clear with IMB about Isabella needing to have her needs met.

4.24 Coercive control is not primarily a crime of violence, but it is firstly and foremost what the acknowledged international expert on the topic, Stark (2007) describes as a liberty crime. Stark provides a detailed breakdown of the behaviours that comprise coercive control, taking full account of the findings of the criminal investigation some of these though do fit the actions and behaviour of IMB in this case:

'Intimidation (including threats, surveillance, stalking, degradation and shaming), Isolation (including from family, friends and the world outside the home); and Control (including control of family resources and 'micromanagement' of everyday life').[9]

4.25 Ipswich Borough Council (IBC) were approached the same day, 19th of June, that the Consultant Social Worker from Norfolk was talking to IMB. IM and IMB claimed to Ipswich Borough Council that they were homeless and fleeing violence. It was decided to offer the couple temporary accommodation at one of the Council's Homeless Hostels, which is staffed 24/7.

4.26 A Domestic Abuse link worker, for Ipswich Borough Council became involved to gain more information and to ensure that safety measures were in place. The worker called the family twice on Tuesday the 20th of June leaving voicemails introducing herself and asking for contact to be made. No response was received. Calls were made again on Wednesday 21st of June and in the end contact was made with the hostel staff who advised the family that the Ipswich Borough Council DA link worker was trying to call them.

4.27 The Ipswich Borough Council DA link worker called again that afternoon where she had a conversation with IMB, who passed the phone to IM who said they were OK and Isabella was fine and had settled well and they had all they needed. The DA link worker felt she had established the family were safe and there was no reason to believe that IF (alleged perpetrator) knew where they were. The DA link worker called the Suffolk MASH to inform them that Ipswich Borough Council were submitting

[9] Stark, E., Coercive control. The entrapment of women in personal life. (U.S.A: Oxford University Press, 2007).

a referral, which they did, outlining concerns about IMB. Staff at the Hostel though were not aware that a referral had been made. Whilst the information could be found on the computer system, staff were not informed directly.

4.28 CBC expressed their concern about Isabella's welfare via an email sent from them to both Norfolk and Suffolk. They were worried about the adults who were refusing to tell them where they were and acknowledged they had no money. The Team Manager stated they may have need of Police assistance. The Norfolk County Council CADS provided CBC with the address of a relative of IMB in Ipswich given to them by him. It would have been beneficial to have expanded on what the worries were and why police assistance might have been necessary.

4.29 The Child Safeguarding Practice Review Panel briefing (September 2022) on Multi-agency safeguarding and domestic abuse[10], states that:

> *'There appeared to be an assumption that simply naming 'domestic abuse' as a concern for a child is enough for all practitioners to understand the situation and respond appropriately. This is an overly simplistic, optimistic and, at times, dangerous assumption that leads to potentially avoidable harm to children and non-abusing parents.' Statutory and voluntary sector services working with children and adults require detailed understanding of abusers' use of controlling and coercive behaviour.'*

4.30 It is clearly evident from this review that the learning from this thematic is important for practitioners to be aware of.

Key Learning

- Domestic abuse is always harmful to children regardless of their age.
- Domestic abuse can occur between both male and females as victims and perpetrators and assumptions should not be made that the female (IM in this case), would act protectively.
- A DASH or DARA risk assessment should have been completed by all agencies when being told about domestic abuse by an alleged victim, it should not be presumed that another agency/professional is completing and submitting one.
- Professionals should equally not rely on the actions of others as this could give false assurance, they should always act on the risks as they find them.
- Professionals should ensure they fully understand the risks of coercive and controlling behaviour.

5.0 Information sharing between agencies in Central Beds/Hertfordshire/Norfolk/Suffolk during the final month of Isabella's life.

5.1 IM was in receipt of cross border working arrangements between two maternity services. During this time period the two services did not meet as routine, however, this is now in place in the form of the Bedfordshire health pre-birth tracking meetings and information sharing meeting. These meetings support information sharing for women where there has been an information sharing form completed and there are unmet needs which require a dual response for women who are accessing shared care.

5.2 The lack of joined up digital systems does not lend itself to supporting the triangulation of safeguarding information and relies on maternity and health visiting service clinicians seeking to establish this information directly from wider professionals. In this case there was a lack of triangulation of the information which could have been held by those agencies who are outside of these particular health partners. This information could have provided a more comprehensive

[10] Child Safeguarding Practice Review Panel (CSPRP) (2022) Multi-agency Safeguarding and domestic abuse. https://www.gov.uk/government/publications/multi-agency-safeguarding-and-domestic-abuse-paper

understanding of IM's needs, and despite the digital challenges, this was also not sought via inter-professional communication.

5.3 The practice when IM was undergoing assessment (not yet formally diagnosed) as having ADHD, was said by their IMR author to not be in line with policy and good practice. The CMHT had worked with IM and was aware of her history and therefore, on receiving the concerns regarding her wellbeing would have been the right team to have followed up on the safeguarding concerns raised on both occasions, particularly in respect of alleged domestic abuse where it was known that a child was in the house.

5.4 According to ELFT procedures, a safeguarding visit should have taken place, consideration should have been given to completing a DASH assessment, MARAC referral, Care Act Assessment, Carer's assessment and safeguarding concern depending on the outcome of the visit. The reason this did not take place was because the team mis-interpreted the delegated Social Care duties for Adult Social Care for service users on the ADHD pathway. There has since been work undertaken to ensure that this, and all other CMHT's are aware of their responsibilities to people who are referred for an ADHD assessment and/or are on the waiting list for an ADHD assessment.

5.5 Isabella had attended Lister Hospital Children's Emergency Department on three occasions between March 2021 – December 2021. It recognised that in view of Isabella's age at that time, further information sharing was completed between the Hospital Trust and the relevant Health Visiting Service.

5.6 There was information available within mental health services about risks and vulnerabilities for both IM and IMB. This information was not sought and not shared. When the online autism assessment was taking place, this was the first time that the mental health services were aware that IM had had a baby.

5.7 During May 2023 when the alleged domestic abuse incidents were taking place between Isabella's parents, the maternal grandmother, who had lots of contact with Isabella, could have been contacted by Bedfordshire Police or CBC Children's Services to see what information she held that might have helped evaluate the risks to Isabella. In the Arthur Labinjo-Hughes and Star Hobson National Child Safeguarding Practice Review this was highlighted as learning for professionals, '*Ensure that all assessments undertaken by agencies draw on information and analysis from all relevant professionals, wider family members or other significant adults who try and speak on behalf of the child.' 'As well as featuring prominently in Arthur and Star's stories, the impact of not considering grandparents' and other adults' views…is highlighted in other serious case analyses (OFSTED, 2011; Brandon et al.*2020.)'[11]

5.8 Information via agency checks was sought and provided, however, the analysis and decision making were taken by the CBC Children's Services Access and Referral Social Workers and managers. Therefore, there was not a multi-agency evaluation of information and collaborative decision making, which could have helped. (In relation to these referrals involving domestic abuse, a trial is in place in CBC of daily domestic abuse meetings held as a multiagency group. This currently includes the Police, Children's Centres and domestic abuse partners. The intention is that in the future they will include health, IDVA, education, housing and early help partners to review the information and decision-making regarding threshold and action.)

5.9 Hertfordshire Constabulary could have alerted Bedfordshire Police to the contact of June the 6th, given that the subjects had been resident within Central Bedfordshire. They could have also notified Norfolk as they had been told that Isabella was there. When the maternal grandmother visits Great

[11] Child Safeguarding Review Panel (2022)- 'Child Protection in England- national review into the murders of Arthur Labinjo-Hughes and Star Hobson. DfE London.

Yarmouth Police station a few days later, they could have made a record and shared with their officers the grandmothers concerns.

5.10 In Norfolk there appears to have been a lot of community support for the family since they arrived, which was clearly well intentioned but has also clouded the picture of who was doing what, where and when. There appears to be people who have a professional role i.e., the concerned citizen (domestic abuse worker) who was believed to have been brought on board by those who befriended the family in the community but wasn't acting in this professional role during her interactions with the family. This provided a false assurance to professionals.

5.11 Norfolk Children Services became aware of the family on the 17th of June via the Emergency Duty Team and the case was passed to them on the 19th of June 2023. This was following referral after the family were intercepted on the beach by Norfolk Police. MASH checks were completed to try to establish some contact details for IM, as essentially Isabella was deemed a Child in Need in Norfolk due to the housing situation, and it was essential to understand who was doing what. The concerned citizen made contact with the duty social worker and advised them that she had been chiefly responsible for the family over the weekend and had secured accommodation for them until the 19th of June as they were fleeing alleged domestic abuse. The duty social worker completed checks with CBC Children's Services who confirmed the family were known in the past but not open for any current involvement.

5.12 There were a number of emails exchanged between Norfolk and Central Bedfordshire Council on the 19th of June around responsibility. Central Bedfordshire Council Children's Services were in contact saying they were dealing with the matter as they had been in conversation with IM during the day and that the Access and Referral Team in CBC would be supporting.

5.13 The transfer of cases between areas is problematic and not unique to this case; it can too often lead to episodic and often 'siloed' decision making, particularly when a family moves from place to place. Whilst there was an incredible amount of information sharing between the local authority areas that did take place, better join-up across the local authorities and clearer understanding of roles and responsibilities is needed whilst keeping the safety of children in mind. At present, the originating authority hands over the responsibility to the host authority (unless the child is on a Child Protection plan). Agreements and protocols should be put in place in cases such as these, whereby the originating authority is responsible for leading the work with the host authority in partnership. It is recommended that a regional or national policy is developed in line with similar examples of the pan-London and Welsh authorities' procedures would aid clarification.

5.14 The procedure in these sorts of cases appears to be to hand over responsibility almost as soon as they move (if not on a Child Protection Plan) and this presents potential for knowledge to be lost. An IMR author suggested that whilst a transfer does have to take place at some point, the original owner could possibly do more. This could take the form of a joint visit with the new authority because this would ensure that changes were identified, rather than the new authority having to start from the beginning. This may be complex and at times, unrealistic especially if the new authority is a long distance away however ensuring the whereabouts and safety of a child should always be prioritised.

5.15 Better communication across the local authorities and a more joined up way of working across the agencies from different services that are involved is needed. Consideration for professionals meeting, where cases are complex and numerous people are involved, to have a full understanding of the current situation and risks. This would have helped in this case as all the conversations were only on a 1-1 basis.

Key Learning

- Joined up management information systems in Health departments would aid shared patient records. There was very little information sharing pre and post the birth of Isabella.
- The mental health information regarding IMB was not sought or shared which was important information in relation to the risks he posed to Isabella.
- The Missing From Home concerns were not shared with the area Isabella normally resided in, and/or the area she was believed to be in.
- The voice and information of Central Bedfordshire Council was not being given the due cognisance it deserved.
- The issues of cross-border moves and the barriers to information sharing need resolving on a local and national basis. The movement of the family from Central Bedfordshire Council to Norfolk, and then Suffolk was a barrier to effective information sharing and decision making as numerous agencies were involved.

6.0 Housing - when families are homeless and young children are involved.

6.1 Central Bedfordshire Council received two homeless applications from IM. The first was made on 21st of February 2022, because she had been asked to leave her privately rented accommodation after getting into financial difficulties. IF was included on the application as a member of her household. Following this application, they were provided with transitional accommodation pending the outcome of her homeless application.

6.2 The family were under financial pressures as they were in debt from a previous property, they had rented during Covid. The temporary accommodation hostel was charging a high rent and the family struggled to use the washing machines due to the cost of doing so. IM's workplace offered them the use of their laundry facilities. Due to the location of the hostel IM and Isabella had to cross the busy A1 road each day with Isabella in a buggy. During the winter months staff from her place of work would collect and drop them to and from the hostel to ensure their safety, as the nearest crossing was a distance in the opposite direction to walk and was often flooded once over the bridge. The hostel was though the closest temporary accommodation available to support IM's needs with it being only a 10 mins drive from her parents and a six min drive (or 30 mins walk) from her place of work and it allowed the family to maintain their established links and employment at the time.

6.3 Before placing any household in temporary accommodation, CBC Housing undertake a robust risk assessment which considers the household make-up, medical conditions, income and have regard to their Transitional Accommodation placement policy which has regard to:

- Location – is it within Central Bedfordshire
- Size, condition, and Facilities of the accommodation
- Health Factors of the family
- Employment
- Proximity to schools and services.

6.4 The family fell behind with their hostel rent and were threatened with eviction. The landlord asked for a meeting with IM, because for some reason IF was not allowed to attend, a manager from her workplace went with her to support her and to help put a financial plan in place to avoid eviction. IM's workplace then helped in contacting the allocated housing officer and Citizens Advice for further support, however, neither offered any help. IM kept having her housing forms rejected when applying to access the housing, this was mainly due to her not being able to understand what was being

requested. Her workplace supported her to complete the application so that she was able to bid for properties.

6.5 IM and IF were unable to pay for their hostel debt and pay childcare fees. So, the workplace decided to offer free childcare for three months to ensure that Isabella was in a better environment during the day than the hostel they were staying in and to support the parents in catching up with their rent arrears so they would not be evicted.

6.6 In the view of IM's workplace, they felt that the Housing Support Officer did not support the family and only seemed to communicate via emails, which IM did not understand the content of. CBC Housing state that they were not aware of any vulnerabilities of IM in terms of her needing support to understand content of written communication.

6.7 Within the CBC Housing IMR it states: *'The homelessness code of guidance (2018) recommends that customers are offered multiple channels to make homelessness application and suggests that at least one face to face meeting had taken place. As there were not facilities available to see the mother face to face before as part of establishing its duties to her an opportunity was potentially missed to pick up on any vulnerabilities/ issues She or Isabella or any concerns. If such concerns were raised/observed a safeguarding concern would have been flagged. The Housing service plan to re-introduce face to face contact into day-to-day practices as soon as a suitable location for interviews rooms is sourced*.' To add clarity to this comment, this only applies for the first application and as Isabella and her family were in temporary accommodation at this time it wouldn't have applied but would have done when IM re-applied after her and IF separated. A location to carry out the face-to-face meetings has been identified and it should hopefully resolve some of the issues that IM encountered.

6.7 During the family's stay in the hostel they were placed in the transitional accommodation hub, which is staffed throughout the day and security is available at night. The family appeared to be happy, and staff noted that both parents doted on Isabella who appeared to be well cared for. There were no reports or concerns during this period of domestic abuse, or any safeguarding concerns regarding Isabella. There were also no complaints from other residents or concerns of anti-social behaviour about them.

6.8 The family moved into a more permanent accommodation in 2023 but on the 22nd of May 2023, two months after moving into this tenancy, IM made a second homeless approach, claiming she was fleeing domestic abuse from IF.

6.9 Throughout the 23rd and 24th of May 2023, housing officers were working with CBC Children's Services to address IM's living situation. On the 24th of May 2023, IM was offered an interim temporary accommodation placement in Central Bedfordshire. At this point IM disclosed that she had a new partner (IMB) and ultimately declined this accommodation when she was advised that only people who were part of her household could stay in her temporary accommodation. There are no records to indicate that the housing officer collected the details of the new boyfriend. Housing Officers felt that they had discharged their duties to provide interim accommodation following her refusal of accommodation. The decision of CBC Housing to a) not include IMB as a person reasonably expected to reside with IM because it was a new relationship; and b) to discharge the duty to provide interim accommodation, can be viewed as reasonable decisions for the authority to reach in respect of its duties. However, particularly in relation to ending the interim duty, before making these decisions, the review author is of the opinion that housing officers could have placed greater emphasis on the mothers disclosed vulnerabilities (e.g., domestic abuse/ mental health/ADHD) and how these vulnerabilities would affect her own decision -making as well as understanding more about IMB. IM's reasons for declining accommodation should have been shared with CBC Children's Services as this likely would have sparked questions about IMB earlier and triggered a multi-agency response, as there

is a recognition that CBC Housing Officers were more than likely the first agency to have become aware of IMB.

6.10 When IM reported that she was told she could be removed from the joint tenancy agreement, and the option was to seek temporary accommodation for her and Isabella. This would likely jeopardise IM getting to work and the nursery which Isabella attended and the potential temporary accommodation was close to where IF worked. Research indicates that this was a critical point as the relationship with IF had ended. It is not evident that research and this practice knowledge was considered when concluding no further action. This is an area of learning, for Housing departments and CBC Children's Services Access and Referral Hub could have requested housing to review this decision and escalated this housing decision as IM had priority need as the main carer and therefore housing had a duty to IM and Isabella.

6.11 One of the key issues and potential areas of learning relates to housing support for victims of domestic abuse. Further clarity may be required in relation to the response that IM received as a victim caught in the situation of having to leave her and Isabella's community of support, the family home and her employment. It is identified that Local Authority's provide different responses to families fleeing domestic abuse and attending their area. Statutory guidance on this matter is clear. The Homelessness code of guidance for local authorities (Department of Levelling Up, Housing and Communities; May 2023, 8.1) states *'local authorities must still comply with their duties under homelessness law and 'that a person who is homeless as a result of that person being a victim of domestic abuse will have a priority need for accommodation under the homelessness legislation'*. Different housing authorities will have different services and pressures within their own areas. One of the options is to consider a women's refuge but such accommodation in almost every area is limited. But in practical terms in this case it would have been unrealistic to have offered a housing solution that both kept IM close to her family support and employment, but also a safe distance from IF because they both worked and resided in the same area/s and there was a high prospect of the mother being seen by IF.

6.12 On the 1st of June 2023, IM and Isabella leave Bedfordshire saying she is fleeing the alleged domestic abuse. IMB is with them, they travel to Great Yarmouth where they stay in a local hotel.

6.13 Great Yarmouth Borough Council received an online housing application on the 2nd of June 2023. This was a joint application from IM and IMB stating that they were homeless. They stated that IMB was an adult sibling of IM (obviously not true) and that he had lived locally to Great Yarmouth since May 2023. Confusingly they had also selected that IMB was a spouse/partner elsewhere on the form.

6.14 Additional information was provided by IM on the 4th and 7th of June to support the application. The three of them attended Great Yarmouth Borough Council's (GYBC) Housing Office to make their Homeless Application during which IM declared that IMB was Isabella's biological father (this is not true). Phone contact was made with CBC Social Worker. Additional contact was made via email with the Homeless Caseworker at CBC. As mentioned earlier in this report Great Yarmouth Housing didn't though refer Isabella to Norfolk County Council Children's Services at this time..

6.15 They were then seen by the Duty Housing Officer. Emergency accommodation was offered for IM and Isabella only. IMB queried this and then became angry and left the interview room abruptly.

6.16 On the 13th of June, a further email exchange between CBC and Great Yarmouth Borough Council, explaining that an open application existed with CBC which was at triage stage.

6.17 On the 16th of June the family were advised by the police officers that the tent they were staying in on the beach was inappropriate accommodation and moved them off the beach. Staff at the holiday camp in Caister had been providing food and letting the family use their facilities while they stayed on the beach. Temporary accommodation over that weekend was provided for them and arranged and by the concerned citizen.

6.18 On the 19th of June 2023 they left Norfolk in the afternoon by train and travelled to Ipswich in Suffolk, where they found out that staying with a relative of IMB was not possible, so they contacted Ipswich Borough Council (IBC) Customer Service Team. The housing team there decided that the homeless status of Isabella was Ipswich Borough Council's priority as they could not have a family with a young child sleeping rough on the streets. As such the family were offered temporary accommodation at a hostel from the 19th of June, whilst Ipswich Borough Council assessed their application for housing in the Ipswich area. The hostel was a staffed unit and was seen as appropriate accommodation while the families' application for housing in the Ipswich area could be assessed. They turned up at the hostel late in the evening of the 19th of June 2023.

6.19 As already mentioned earlier in this report, when a Safeguarding referral has been made by Housing Options staff, they should ensure that staff at the relevant hostel are made directly aware, rather than expecting them to see it on the relevant computer system and to undertake a welfare check of children in the hostel where safeguarding is under consideration. Staff have now been made aware of this requirement.

6.20 Within the CBC Housing IMR it states: '*There is research which suggests that there is a link between ADHD and toxic relationships and that those with ADHD can also experience homelessness.'* This is relevant learning for this case.

Key Learning

- Professionals should consider when an applicant declines accommodation, why they are declining and their vulnerabilities, before closing the application.
- Professionals should always obtain full details of anyone else likely to reside in the accommodation, especially if there are children living in the household.
- At the point of separation, research suggests that this heightens a period of vulnerability.
- When reported homeless in Great Yarmouth, the refusal to accept accommodation offered, unless IMB was housed as well, should have raised concerns.
- Great Yarmouth Housing didn't though refer Isabella to Norfolk County Council Children's Services at this time where safeguarding concerns had been identified.
- Families living on the beach (rough sleeping) or in other unsuitable accommodation, should raise concerns of neglect and other vulnerabilities for the children involved.
- Research suggests there is a link between ADHD-Toxic relationships-Homelessness.

7.0 Considerations around intersectionality-race, disability and health conditions and whether these impacted on service delivery

7.1 The Child Safeguarding Practice Review Panel guidance for safeguarding partners that was published in September 2022 states that:

> *'Intersectionality is the interconnected relationship of social categorisations such as race, gender, and sexual orientation together with individual vulnerability and adversities suffered by the individual. It is important to consider the potential to learn from issues of 'intersectionality' at each stage of the process – particularly when considering the usefulness of an LCSPR[12].'*

7.2 IMB had a diagnosis of ADHD and Autism which is a disability under the Equality Act 2010. This triggers the duty to consider reasonable adjustments in line with the needs of the person. The review author was not fully aware of this being a disability under the Act and although accepting that some

[12] Child Safeguarding Practice Review Panel (CSPRP) (2022) Guidance for Safeguarding Partners https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1108887/Child_Safeguarding_Practice_Review_panel_guidance_for_safeguarding_partners.pdf

professionals, in particular those who work in Health and Education are aware, he is conscious that this is learning that should be shared wider amongst all professionals.

7.3 Whilst at school IM had an Individual Education Plan (IEP) and was supported by Autism Bedfordshire, Occupational Therapy, Speech and Language Therapy.

7.4 Not long after Isabella was born IM had an appointment for an on-line autism assessment. The record of the appointment states: *'Mother had her 3 month old daughter with her during the appointment who was crying constantly, the appointment had to be abandoned.*'

7.5 IM had an initial ADHD assessment on 7th of March 2023, which indicated a diagnosis and in line with the ADHD pathway, the next step was to arrange for an appointment with the consultant to confirm the diagnosis, undertake physical health tests and provide ADHD information and resources to IM. The IMR author for the health agency involved states: '*for patients who are on an ADHD waiting list, consideration should be given to the difficulties they may have to keep appointments or engage in appointments and treatments. Consideration should be given to what adjustments are necessary to support them whilst they are waiting for a diagnosis.'*

7.5 When IM applied for, and entered employment, she disclosed on her medical questionnaire that she had a disability and also that she has suffered with depression, stress related illness and mental health problems.

7.6 One of her employers stated in their IMR that IM, *'needed support from staff to help her understanding of information she was given and to have regular health and wellbeing meetings to support her mental health. She disclosed that she was going through the assessments at Bedford Hospital for ADHD and Autism*.'

7.7 The employer also stated that IM was on their vulnerable staff register. In their opinion, '*there was opportunity over the years when the mother was known to them that she could have been given an adult social care worker to support her in her adult life, being a young vulnerable mum who was going through diagnosis for health conditions such as ADHD and Autism.'* The review author supports this view.

7.8 There is little evidence that reasonable adjustments were considered in line with IM and IMB's disability, for additional support offered to help them engage better. Consideration should have been given to ensure that there was a 'reasonable adjustments flag' on electronic systems with a health passport for patients who are open to multiple teams to improve communication.

7.9 Examples of reasonable adjustments that may have been helpful for them are:

- Extra reminders of appointment times, i.e., text messages, phone calls and letters.
- Supporting them to ensure they have reminders on their phones and personal calendars.
- Considering the appropriateness of virtual assessments and phone reviews.
- Considering the time and location of the appointments.
- Additional support with organising prescriptions and obtaining medication.
- Adjustments to the disengagement policy.

Key Learning

- Professionals need to be aware that ADHD and autism are disabilities and reasonable adjustments are required.
- There was little evidence of reasonable adjustments being applied for IM to help her to engage more effectively.

8.0 Impact of Covid-19

8.1 The ante-natal and post-natal periods for Isabella and IM were during periods of the Covid-19 pandemic when the country was in lockdown. This understandably involved a number of face- to- face services, whether in the home or in a clinic not being able to operate as they once did. This was exacerbated by the immense strain placed on health agencies by the pandemic.

8.2 However, the review author from analysing the rapid review and all of the IMRs can see that there was no detrimental impact on care for Isabella and IM during Isabella's ante-natal and post-natal period.

8.3 From a housing point of view, the shift to return to face- to- face appointments would only help for someone as vulnerable as IM and her difficulty in understanding and completing forms. This is now in progress and suitable spaces have been identified as a result of the learning into this case.

Key learning

- Face-to-Face meetings should take place for someone with vulnerabilities, similar to IM, who had difficulties understanding and completing forms.

9.0 Conclusion

9.1 In the Child Safeguarding Practice Review panels 2020 Annual report,[13] 'Patterns in practice, key messages and 2021 workplan.' the report makes the following comments:

'From our analysis we have highlighted six key practice themes to make a difference in reducing serious harm and preventing child deaths caused by abuse or neglect. These themes are not new, but they are amongst the most urgent, and also the most difficult. Underpinning all of them is the importance of effective leadership and culture – dimensions which are too often left unexplored in the case reviews that we see. We expect these six themes to be a focus for shared learning with safeguarding partnerships, and nationally, to improve the safeguarding system.'

'Six key practice themes to make a difference

1. Understanding what the child's daily life is like

2. Working with families where their engagement is reluctant and sporadic

3. Critical thinking and challenge

4. Responding to changing risk and need

5. Sharing information in a timely and appropriate way

6. Organisational leadership and culture for good outcomes.'

9.2 All of these key pieces of learning from this annual report are clearly evident in this review for Isabella and have been explored in the analysis sections of this report. What it does show is that the safeguarding system across all four of the Local Authority areas, acted in an episodic and often 'siloed' decision making way, particularly when the family moved from area to area, often at speed.

9.3 Examples of this siloed decision making, are that IM had clear and recorded vulnerabilities, not just for herself, but in particular her vulnerabilities as a parent of Isabella. This impacted on her parenting, which wasn't ever considered in a multi-agency forum. Isabella's voice or her lived experience was not seen at all during the last month of her life and not demonstrated in professionals'

[13] https://www.gov.uk/government/publications/child-safeguarding-practice-review-panel-annual-report-2020

actions. The lack of knowledge of who IMB was and an examination of his records, in particular his autism, ADHD and mental health records, and what were the risks he could pose to IM and Isabella, were never considered. IMB's previous partner, if spoken to by an experienced domestic abuse worker or an IDVA, would, it is reasonable to say, have disclosed his extreme coercive controlling behaviour to her. Good information gathering happened but no multi-agency discussions took place, in particular when the concerns for Isabella were rising during the crucial June 2023 period. The focus and discussion as to which service should take responsibility from the respective three Local Authorities, Children's Services, and relevant Housing services, was problematic. This focus may have detracted from the action required at the time and was a potential obstruction to putting the right support in at the right time. A lack of escalation was evident. The omission to contact Adult Mental Health Services as a multi-agency partner to gain insight and information in respect of IM and IMB, might have contributed to wider multi-agency risk management and subsequent actions or decisions and should have happened.

9.4 The episodic nature of interventions is also evident, shown in the way the alleged domestic abuse between the parents of Isabella and how that impacted on her were recorded and dealt with. The unstable and unsuitable housing situation throughout the majority of Isabella's life, and in particular that last few months, was dealt with each time individually, including the stark financial situation IM was in throughout the life of Isabella. There was an over reliance of the housing domestic abuse worker who was supporting the family in a personal capacity, as a concerned citizen and not in a professional capacity. The timeliness of Isabella being seen once in Ipswich and the commencement of an assessment, which never happened, is also a clear example of this episodic approach, rather than concerns of cumulative harm.

9.5 One of the IMR's made a good suggestion that there needs to be developed, regional or national cross-border guidance which includes the opportunity for Children's Services to request welfare visits, and/ or request a Section 47 is initiated in the locality where the child is. This would support optimum practice. A potential host site could be the Association of Directors of Children Services (ADCS) website like the one which is used for looked after children placed in other Local Authorities.

10.0 Recommendations

4.1 This CSPR has identified learning and made some recommendations, as detailed below, and the implementation of these will assist the CBSCP and the other local authorities to deal more effectively with similar circumstances in the future, resulting in the improved safety and welfare of children.

Recommendation 1 The Central Bedfordshire Safeguarding Children Partnership (CBSCP) should share this review report with the Norfolk and Suffolk Safeguarding Children Partnerships for them to consider if there is any learning that they would wish to consider actioning within their area. (System and Practice)
Recommendation 2 The CBSCP should seek assurance from all agencies that they always include the voice and lived experience of a child in their actions and assessments. This includes children who are toddlers, who are unable to fully communicate verbally. In order to provide improvement in this area of practice, agencies need to provide evidence of the methods that they are using in order to ensure that their practitioners are really seeing the children in order to understand what daily life is like for them. (Practice)
Recommendation 3 The CBCSP should ensure that all agencies are reminded of the need to ensure that assessments and interactions with families consider the role, presence and the history of male and female partners living in, or associating closely within a household. This could be widened to include all carers to children. (Practice)

Recommendation 4 (i)The CBCSP need to ensure that all professionals are aware of the options that Housing have in similar type cases where domestic abuse and neglect is a feature and there are children who are being impacted by being homeless or in unsuitable accommodation. This should include the need for agencies to follow the Duty to Refer guidance. (Practice) (ii) Housing departments and Housing societies need to be briefed on this case to understand the risks to children from domestic abuse and also of being homeless. The Housing departments and Housing societies need to be reminded of their responsibilities to children and their duty to complete a safeguarding referral to Children's Services where abuse and neglect are identified or suspected. (System) (iii) The CBSCP should ensure that their neglect strategy is adequately able to identify that unsuitable accommodation and rough sleeping are risk factors of neglect for children and their families. (System)
Recommendation 5 (System-Practice) The CBSCP need to raise professionals' awareness, knowledge and understanding of domestic abuse and neglect: ii) Ensuring that front-line staff can recognise the signs and symptoms of coercive and controlling behaviour as a key form of domestic abuse. ii) The fact that household domestic abuse and neglect is always harmful to children. iii) That all statutory agencies recognise the necessity to complete DASH/DARA's where a disclosure of domestic abuse has been made, and that this is embedded into procedures and day to day practice. iv) Where children are in a household or around adults where domestic abuse and neglect is present, that a children's safeguarding referral should automatically follow alongside any domestic abuse referrals. v) Statutory professional partners undertake training to identify strategies to disrupt perpetrators of domestic abuse and how to better identify neglect and take action as appropriate.
Recommendation 6 (System) The CBSCP should promote the use of: (i) Multi-agency meetings to improve information sharing and assessment of risk. This should include cross border information sharing and assessment of risk decision making. There are no multi-agency meetings evidenced in this case. (ii) The use of management oversight and supervision to cross check decision making and formal escalation needs to be highlighted to all professionals and agencies.
Recommendation 7 (Practice) The CBSCP should recommend that all professionals consider individual learning needs and make reasonable adjustments, regardless of whether the individual has a formal diagnosis of disabilities or additional needs, such as ADHD.
Recommendation 8 (System) The CBSCP should initiate the discussions with the National Panel for this recommendation to be a national issue, which is for them to consider development of regional or national cross-border guidance which includes the opportunity for a resident that their Children's Services are able to request welfare visits, and if necessary for a Section 47 to be initiated in the area the child is now resident.